

A Great Opportunity for Very Valuable Healthcare Coverage

Welcome to the Connecticut (CT) Partnership Plan—a low-/no-deductible Point of Service (POS) plan now available to you (and your eligible dependents up to age 26) and other non-state public employees who work for municipalities, boards of education, quasi-public agencies, and public libraries.

The CT Partnership Plan is the same POS plan currently offered to State of Connecticut employees.

You get the same great healthcare benefits that state employees get, including \$15 in-network office visits (average actual cost in CT: \$150*), free preventive care, and \$5 or \$10 generic drug copays for your maintenance drugs. You can see any provider (e.g., doctors, hospitals, other medical facilities) you want—in- or out-of network. But, when you see in-network providers, you pay less. That's because they contract with Anthem Blue Cross and Blue Shield (Anthem)—the plan's administrator—to charge lower rates for their services. You have access to Anthem's State Bluecare POS network in Connecticut, and access to doctors and hospitals across the country through the BlueCard® program.

When you join the CT Partnership Plan, the state's Health Enhancement Program (HEP) is included. HEP encourages you to get preventive care screenings, routine wellness visits, and chronic disease education and counseling. When you remain compliant with the specific HEP requirements on page 5, you get to keep the financial incentives of the HEP program!

Look inside for a summary of medical benefits, and visit www.anthem.com/statect to find out if your doctor, hospital or other medical provider is in Anthem's network. Information about the dental plan offered where you work, and the amount you'll pay for healthcare and dental coverage, will be provided by your employer.



POS MEDICAL BENEFIT SUMMARY

BENEFIT FEATURE	IN-NETWORK	OUT-OF-NETWORK		
Preventive Care (including adult and well-child exams and immunizations, routine gynecologist visits, mammograms, colonoscopy)	\$0	20% of allowable UCR* charges		
Annual Deductible (amount you pay before the Plan starts paying benefits)	Individual: \$350 Family: \$350 per member (\$1,400 maximum) Waived for HEP-compliant members	Individual: \$300 Family: \$900		
Coinsurance (the percentage of a covered expense you pay <i>after</i> you meet the Plan's annual deductible)	Not applicable	20% of allowable UCR* charges		
Annual Out-of-Pocket Maximum (amount you pay before the Plan pays 100% of allowable/UCR* charges)	Individual: \$2,000 Family: 4,000	Individual: \$2,300 (includes deductible) Family: \$4,900 (includes deductible)		
Primary Care Office Visits	\$15 CODAY (\$0 copay for Preferred Providers)	20% of allowable UCR* charges		
Specialist Office Visits	\$15 COPAY (\$0 copay for Preferred Providers)	20% of allowable UCR* charges		
Urgent Care & Walk-In Center Visits	\$15 copay	20% of allowable UCR* charges		
Acupuncture (20 visits per year)	\$15 copay	20% of allowable UCR* charges		
Chiropractic Care	\$0 copay	20% of allowable UCR* charge		
Diagnostic Labs and X-Rays¹ ** High Cost Testing (MRI, CAT, etc.)	\$0 copay (your doctor will need to get prior authorization for high-cost testing)	20% of allowable UCR* charges (you will need to get prior authorization for high-cost testing)		
Durable Medical Equipment	\$0 (your doctor may need to get prior authorization)	eed to 20% of allowable UCR* charges (you may need to get prior authorization)		

¹ IN NETWORK: Within your carrier's immediate service area, no co-pay for preferred facility. 20% cost share at non-preferred facility. Outside your carrier's immediate service area: no co-pay.

¹ OUT OF NETWORK: Within your carrier's immediate service area, deductible plus 40% coinsurance.

Outside of carrier's immediate service area: deductible plus 20% coinsurance.



POS MEDICAL BENEFIT SUMMARY

BENEFIT FEATURE	IN-NETWORK	OUT-OF-NETWORK		
Emergency Room Care	\$250 copay (waived if admitted)	\$250 copay (waived if admitted)		
Eye Exam (one per year)	\$15 copay	50% of allowable UCR* charges		
**Infertility (based on medical necessity)	2			
Office Visit	\$15 copay	20% of allowable UCR* charges		
Outpatient or Inpatient Hospital Care	\$o	20% of allowable UCR* charges		
**Inpatient Hospital Stay	\$o	20% of allowable UCR* charges		
Mental Healthcare/Substance Abuse Treatment	2	· · · · · · · · · · · · · · · · · · ·		
**Inpatient	\$o	20% of allowable UCR* charges (you may need to get prior authorization)		
Outpatient	\$15 copay	20% of allowable UCR* charges		
Nutritional Counseling	\$0	20% of allowable UCR* charges		
(Maximum of 3 visits per Covered Person per Calendar Year)				
**Outpatient Surgery	\$0	20% of allowable UCR* charges		
**Physical/Occupational Therapy	\$o	20% of allowable UCR* charges, up to 60 inpatient days and		
		30 outpatient days per condition per year		
Foot Orthotics	\$0 (your doctor may need to get prior authorization)	20% of allowable UCR* charges (you may need to get prior authorization)		
Speech therapy: Covered for treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx	\$o	Deductible plus Coinsurance (30 visits per Calendar Year)		
Medically necessary treatment resulting from other causes is subject to Prior Authorization	\$0 (30 visits per Covered Person per Calendar Year)	Deductible plus Coinsurance (30 visits per Calendar Year)		

^{*}Usual, Customary and Reasonable. You pay 20% coinsurance based on UCR, plus you pay 100% of amount provider bills you over UCR.

^{**} Prior authorization required: If you use in-network providers, your provider is responsible for obtaining prior authorization from Anthem. If you use out-of-network providers, you are responsible for obtaining prior authorization from Anthem.

Be the picture of health

Check out these programs and services to be your healthy best

Need a doctor? Choose a State of Connecticut preferred doctor and save

When you see a Primary Care Physician (PCP) or specialist in your State of Connecticut preferred network (also referred to as Tier 1 in your health plan), there's no office visit copay. These doctors cost less than doctors outside of your plan.

- Visit anthem.com/statect and choose Find a Doctor.
- Call the Enhanced Member Service Unit at 1-800-922-2232, for more information or to find out if your doctor is in Tier 1.

Use Site-of-Service providers to get 100% coverage for lab tests, X-rays, and high-cost imaging

Site-of-Service (SOS) providers give you 100% coverage with a \$0 copay. Your plan will cover only 80% of the cost when you get these services from other providers.

 Call the Enhanced Member Service Unit at 1-800-922-2232 to learn more.

Find support for mental health issues

If you or a family member needs mental health or substance use care or treatment, we have specialists and designated programs that can help and/or direct you to the type of care that you need.

- Call an Anthem Behavioral Health Care Manager at 1-888-605-0580.
- · Visit anthem.com/statect.

See a doctor, psychologist or therapist from home or work with LiveHealth Online

With LiveHealth Online you can see a board-certified doctor on your smartphone, tablet or computer with a webcam. Doctors can assess your health, provide treatment options and send a prescription to the pharmacy of your choice, if needed.² If you're feeling stressed, worried or having a tough time, you can see a licensed psychologist or therapist through LiveHealth Online Psychology. It's private and in most cases you can see a therapist within 4 days or less.³

 Learn more and enroll at livehealthonline.com or use the free mobile app.





How to find care right away when it's not an emergency

The emergency room shouldn't be your first stop — unless it's a true emergency (then, call 911 or go to the ER). Depending on the situation, there are different types of providers you can see if your doctor isn't available.

- Visit a walk-in doctor's office, retail health clinic or urgent care center.
- Have a video visit with a doctor through LiveHealth Online.
- Call 24/7 NurseLine at 1-800-711-5947 to speak with a nurse about symptoms or get help finding the right care.

Get access to care wherever you go

If you travel out of Connecticut, but are in the U.S., you have access to doctors and hospitals across the country with the BlueCard® program. If you travel out of the U.S., you have access to providers in nearly 200 countries with the Blue Cross and Blue Shield Global Core® program.

 Call 1-800-810-BLUE (2583) to learn more about both programs. If you're outside the U.S., call collect at 1-804-673-1177.³

It's easy to manage your benefits online and on the go

- Find a doctor, check your claims and compare costs for care near you at anthem.com/statect.
- Use our free mobile app (search "Anthem Blue Cross and Blue Shield" at the App Store* or Google PlayTM) for benefit information and to show your ID card, get directions to a doctor or urgent care center and much more

Customer service helps you get answers and much more

The State of Connecticut Enhanced Member Service Unit can give you information on benefits, wellness programs and services and everything mentioned in this flier.

- Call them at 1-800-922-2232.
- Visit anthem.com/statect.

l Designated as Tier 1 in our Find a Doctor tool, Eligible specialities include allergy and immunology, cardiology, endocrinology, ear nose and throat (ENT), gastroenterology, OB/GYN, ophthalmology, orthopedic surgery, rheumatology and urology.

2 Prescription availability is defined by physician judgment and state regulations, 3 Appointments subject to availability of therapist.

4 Blue Cross Blue Shield Association website: Coverage Home and Away (accessed March 2019):

bcbs.com/already-a-member/coverago-home-and-away.html.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf

of Anthem Blue Cross and Blue Shield. Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent

licensee of the Blue Cross and Blue Shield Association. Anithem is a registered trademark of Anithem Insurance Companies, Inc. 59142CTMENABS Rev. 03/19



PRESCRIPTION DRUGS	Maintenance+ (31-to-90-day supply)	Non-Maintenance (up to 30-day supply)	HEP Chronic Conditions
Generic (preferred/non-preferred)**	\$5/\$10	\$5/\$10	\$0
Preferred/Listed Brand Name Drugs	\$25	\$25	\$5
Non-Preferred/Non-Listed Brand Name Drugs	\$40	\$40	\$12.50
Annual Out-of-Pocket Maximum	\$4,600 Individual/\$9,20	o Family	

- + Initial 30-day supply at retail pharmacy is permitted. Thereafter, 90-day supply is required—through mail-order or at a retail pharmacy participating in the State of Connecticut Maintenance Drug Network.
- ++ Prescriptions are filled automatically with a generic drug if one is available, unless the prescribing physician submits a Coverage Exception Request attesting that the brand name drug is medically necessary.

Preferred and Non-Preferred Brand-Name Drugs

A drug's tier placement is determined by Caremark's Pharmacy and Therapeutics Committee, which reviews tier placement each quarter. If new generics have become available, new clinical studies have been released, new brand-name drugs have become available, etc., the Pharmacy and Therapeutics Committee may change the tier placement of a drug.

If your doctor believes a non-preferred brand-name drug is medically necessary for you, they will need to complete the Coverage Exception Request form (available at

www.osc.ct.gov/ctpartner) and fax it to Caremark. If approved, you will pay the preferred brand co-pay amount.

If You Choose a Brand Name When a Generic Is Available

Prescriptions will be automatically filled with a generic drug if one is available, unless your doctor completes Caremark's Coverage Exception Request form and it is approved. (It is not enough for your doctor to note "dispense as written" on your prescription; a separate

form is required.) If you request a brand-name drug over a generic alternative without obtaining a coverage exception, you will pay the generic drug co-pay PLUS the difference in cost between the brand and generic drug.

Mandatory 90-day Supply for Maintenance Medications

If you or your family member takes a maintenance medication, you are required to get your maintenance prescriptions as 90-day fills. You will be able to get your first 30-day fill of that medication at any participating pharmacy. After that your two choices are:

- Receive your medication through the Caremark mailorder pharmacy, or
- Fill your medication at a pharmacy that participates in the State's Maintenance Drug Network (see the list of participating pharmacies on the Comptroller's website at www.osc.ct.gov).



The Health Enhancement Program (HEP) is a component of the medical plan and has several important benefits. First, it helps you and your family work with your medical providers to get and stay healthy. Second, it saves you money on your healthcare. Third, it will save money for the Partnership Plan long term by focusing healthcare dollars on prevention.

Health Enhancement Program Requirements

You and your enrolled family members must get age-appropriate wellness exams, early diagnosis screenings (such as colorectal cancer screenings, Pap tests, mammograms, and vision exams). Here are the 2020 HEP Requirements:

PREVENTIVE SCREENINGS	AGE						
	0-5	6-17	18-24	25-29	30-39	40-49	50+
Preventive Visit	1 per year	1 every other year	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50-64: Every 3 years 65+: Every 2 years
Dental Cleanings	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	Every 5 years (20+)	Every 5 years	Every 5 years	Every 5 years	Every 2 years
Breast Cancer Screening (Mammogram)	N/A	N/A	N/A	N/A	N/A	1 screening between age 45-49	As recommended by physician
Cervical Cancer Screening	N/A	N/A	Pap smear every 3 years (21+)	Pap smear every 3 years	Pap smear only every 3 years or Pap and HPV combo screen- ing every 5 years	Pap smear only every 3 years of Pap and HPV combo screen- ing every 5 years	Pap smear only every 3 years or Pap and HPV combo screening every 6 years to age 65
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years, Annual FiT/ FOBT to age 75 or Cologuard screening overy 3 years



The Health Enhancement Program features an easy-to-use website to keep you up to date on your requirements.



Additional Requirements for Those With Certain Conditions

If you or any enrolled family member has 1) Diabetes (Type 1 or 2), 2) asthma or COPD, 3) heart disease/heart failure, 4) hyperlipidemia (high cholesterol), or 5) hypertension (high blood pressure), you and/or that family member will be required to participate in a disease education and counseling program for that particular condition. You will receive free office visits and reduced pharmacy copays for treatments related to your condition.

These particular conditions are targeted because they account for a large part of our total healthcare costs and have been shown to respond particularly well to education and counseling programs. By participating in these programs, affected employees and family members will be given additional resources to improve their health.

If You Do Not Comply with the requirements of HEP

If you or any enrolled dependent becomes non-compliant in HEP, your premiums will be \$100 per month higher and you will have an annual \$350 per individual (\$1,400 per family) in-network medical deductible.

Care Management Solutions, an affiliate of ConnectiCare, is the administrator for the Health Enhancement Program (HEP). The HEP participant portal features tips and tools to help you manage your health and your HEP requirements. You can visit www.cthep.com to:

- View HEP preventive and chronic requirements and download HEP forms
- Check your HEP preventive and chronic compliance status
- Complete your chronic condition education and counseling compliance requirement
- Access a library of health information and articles
- Set and track personal health goals
- Exchange messages with HEP Nurse Case Managers and professionals

You can also call Care Management Solutions to speak with a representative.

Care Management Solutions

(877) 687-1448 Monday - Thursday, 8:00 a.m. - 6:00 p.m. Friday, 8:00 a.m. - 5:00 p.m.

Summary of Benefits

Cigna Health and Life Insurance Company

Cigna Vision **Town of East Windsor** C1 - Custom PPO Comprehensive Plan



Welcome to Cigna Vision Schedule of Vision Coverage				
Coverage	In-Network Benefit	Out-of-Network Benefit	Frequency Period **	
Exam Copay	\$15	N/A	12 months	
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to \$45	12 months	
Materials Copay	\$0	N/A	12 months	
Eyeglass Lenses Allowances: (one pair per frequency period) Single Vision Lined Bifocal Lined Trifocal Lenticular	Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay	Up to \$40 Up to \$65 Up to \$75 Up to \$100	12 months 12 months 12 months 12 months	
Contact Lenses Allowances: (one pair or single purchase per frequency period) Elective Therapeutic	Up to \$360 Covered 100%	Up to \$345 Up to \$345	12 months 12 months	
Frame Retail Allowance (one per frequency period)	Up to \$175	Up to \$126	12 months	

^{**} Your Frequency Period begins the day after your last visit (Date of service basis)

Copay: the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses).

Coinsurance: the percentage of charges Cigna will pay. Customer is financially responsible for the balance. Allowance: the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance. Materials: eyeglass lenses, frames, and/or contact lenses.

- To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders.
- If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.

In-Network Coverage Includes:

- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;
- One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)
 - o Polycarbonate lenses for children under 18 years of age
 - o Oversize lenses
 - o Rose #1 and #2 solid tints
 - o Minimum 20% savings on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults) all tints/photochromic (glass or plastic); and lens styles.
 - o Progressive lenses covered up to bifocal lens amount with 20% savings on the difference;

07/01/2020

C1 - Custom PPO Comprehensive Plan



- One frame for prescription lenses frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials
- * Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Benefits.

Healthy Rewards® - Vision Network Savings Program:

When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames
and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens
materials. See your Cigna Vision Network Eye Care Professional for details.

What's Not Covered:

- Orthoptic or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- · Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials
- · Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy
- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- Any non-prescription eyeglasses, lenses, or contact lenses
- Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage
- Prescription sunglasses
- Two pair of glasses, in lieu of bifocals or trifocals
- Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

How to use your Cigna Vision Benefits

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

1. Finding a doctor

There are three ways to find a quality eye doctor in your area:

- 1. Log in to myCigna.com, go to your Cigna Vision coverage page and select "View Details." Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.
- 2. Don't have access to myCigna.com? Go to Cigna.com and click on the orange Find a Doctor tab at the top. Then select "Vision Directory", for routine eye exams and eyewear services, from the Other Directories listed below
- 3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision

07/01/2020

C1 - Custom PPO Comprehensive Plan



customer service representative.

2. Schedule an appointment

Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

3. Out-of-network plan reimbursement

How to use your Cigna Vision Benefits

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:

- · Go to Cigna.com and go to Forms, Vision Forms
- · Go to myCigna.com and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

Benefits are underwritten or administered by Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company. Any benefit information displayed is intended as a summary of benefits only. It does not describe all the terms, provisions and limitations of your plan. Participating providers are independent contractors solely responsible for your routine vision examinations and products.

"Cigna" is a registered service mark, and the "Tree of Life" logo, "Cigna Vision" and "CG Vision" are service marks, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries, including Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company, and not by Cigna Corporation. In Arizona and Louisiana, the Cigna Vision product is referred to as CG Vision. Healthy Rewards® - Vision Network Savings Program powered by Cigna Vision is a discount program, not an insured benefit.



Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - · Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator

P.O. Box 188016

Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

ATTENTION: language assistance services, free of charge, are available to you. Call 1-877-478-7557 (TTY: 800-428-4833).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-478-7557 (TTY: 800-428-4833).

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電1-877-478-7557 (TTY:800-428-4833)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-478-7557 (TTY: 800-428-4833).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다1-877-478-7557 (TTY: 800-428-4833) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

07/01/2020

C1 - Custom PPO Comprehensive Plan



Tumawag sa 1-877-478-7557 (TTY: 800-428-4833).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-478-7557 (телетайп: 800-428-4833).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-778-874-775 [(رقم هاتف الصم والبكم: 4833-428-800).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-478-7557 (TTY: 800-428-4833).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-478-7557 (ATS: 800-428-4833).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue 1-877-478-7557 (TTY: 800-428-4833).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezplatnej pomocy językowej. Zadzwoń pod numer 1-877-478-7557 (TTY: 800-428-4833).

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-877-478-7557 (TTY: 800-428-4833) まで、お電話にてご連絡ください。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-478-7557 (TTY: 800-428-4833).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-478-7557 (TTY: 800-428-4833).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 800-428-4833) 7557-478-1-1-1 تماس بگیرید.



Cigna Healthcare Financial Exhibit for:

Town of East Windsor Full ABCD Plan

Effective Date: July 01, 2020



This is a summary of benefits for your dental plan.

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Cigna DPPO - State of CT CSN	Out-of-Network
alendar Year Maximum		
(Class I, II, III, V Expenses)	Unlimited	Unlimited
Major and Minor Periodontal Expenses	\$500	\$500
alendar Year Deductible		
Per Individual	\$0	\$0
Per Family	\$0	\$0
lass I Expenses - Preventive & Diagnostic Care		
Oral Exams	100%, No Deductible	100%, No Deductible
Cleanings	· ·	
Routine X-rays		
Fluoride Application		-
Sealants	2	* · ·
Non-Routine X-rays		
Emergency Care to Relieve Pain	*	*
lass II Expenses - Basic Restorative Care		1009/ No Deductible
Fillings	100%, No Deductible	100%, No Deductible
Oral Surgery - Simple Extractions	46 8	
Root Canal Therapy / Endodontics		
Repairs - Dentures		
Stainless Steel/Resin Crowns	No. of the second secon	
	Not Covered	Not Covered
Anesthetics	Not Covered	Not Covered
Brush Biopsy	Not Covered	Not Covered
Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays	Not Covered	Not Covered
Value 1 (1)		
lass III Expenses - Major Restorative Care		50% No Dodustible
Space Maintainers (limited to non-orthodontic treatment)	50%, No Deductible	50%, No Deductible
Oral Surgery - All Except Simple Extraction		
Surgical Extraction of Impacted Teeth		
Crowns/Inlays/Onlays	M	
Dentures		
Bridges		
lass VIII Expenses - Periodontal		
Minor Periodontal .	50%, No Deductible	50%, No Deductible
Major Periodontal	6700	\$500
Annual Max	\$500	\$500
lass IV Expenses - Orthodontia	60%, No Ortho Deductible	60%, No Ortho Deductible
Coverage for Eligible Children Only	\$600	\$600
Lifetime Maximum	\$000	
Pental Plan Reimbursement Levels	Based on Contracted Fees	85th Percentile of subbmited Charges
dditional Member Responsibility in	None	Yes, the difference between Billed Charges and
xcess of Coinsurance	Hono	plan reimbursement
tudent/Dependent Age	2	5/25

Town of East Windsor Full ABCD Plan

Effective Date: July 01, 2020

Cigna Dental PPO / Indemnity Exclusions and Limitations:

Procedure

Exclusions & Limitations

Exams Prophylaxis (cleanings)

Two per calendar year Two per calendar year

2 per calendar year for people under 19 Bitewings; 2 per calendar year

X-Rays (routine) X-Rays (non-routine)

Model Minor Perio (non-surgical) bite-mings, 2 per scientary years. Panorex: 1 every 3 calendar years. Payable only when in conjunction with Ortho workup Various limitations depending on the service

Perio Surgery

Various limitations depending on the service

Crowns Prosthesis over Implants Replacement every 5 years

Bridges

payable for non-precious metals. No porcelain or white/looth colored material on molar crowns or bridges Replacement every 5 years.

Denlures and Partials Relines, Rebases Adjustments

Replacement every 5 years. Not Covered Not Covered Not Covered

Repairs - Bridges Repairs - Dentures Sealants Space Maintainers

Reviewed if more than once

Reviewed it more and tince
Limited to posterior tooth. One treatment per tooth every three years up to age 16
Limited to non-Orthodonite treatment. No frequency limit for participants under age 14.
When more than one covered Dentel Service could provide suitable treatment based on common dentel
standards, Cigna HealthCare will determine the covered Dentel Service on which payment will be based end the expenses

Alternate Benefit

Orthodonila

that will be included as Covered Expenses. For dependent children, up to age 19

Missing Tooth Provision Lafe Entrant Limit Pre-Trealment Review

The amount payable is 50% of the amount otherwise payable until insured for a specified lime period; thereafter, considered a Class III expense 50% coverage on Class III, IV (if applicable), and V for 12 months Available on a voluntary basis when extensive work in excess of \$200 is proposed

Benefit Exclusions:

- Services performed primarily for cosmetic reasons;
 Replacement of a lost or stolen appliance;
 Replacement of a bridge or denture within five years following the date of its original installation;
 Replacement of a bridge or denture which can be made useable according to accepted dental standards;
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, stabilize periodontally involved teeth, or restore occlusion;
- *Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;

 *Bite registrations; precision or semi-precision ellectments; splinting; Surgical implant of any type;
- Instruction for plaque control, oral hygiene and diet; Denial services that do not meet common denial standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospilal; Charges which the person is not legally required to pay;
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
- Commerciation or investigational procedures and treatments;

 Any injury resulting from, or in the course of, any employment for wage or profit;

 Any sickness covered under any workers' compensation or similar law;

 Charges in excess of the reasonable and customary allowances;

- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);

- For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
 To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
 To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy willen to
- comply with a "no-fault" insurance few or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.

 In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dentel Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored
- * In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizas the national Cigna Dental PPO natwork.

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare

Did you know that all of Cigna's dentel plans include the Cigna Dental Ozal Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides 160% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can access articles on behavioral conditions that impact oral health.

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Prepared by Underwriting. Clgna DPPO Network (P0010)

or made available by your Employer,



Office of the State Comptroller, Healthcare Policy & Benefit Services Division

www.osc.ct.gov/ctpartner 860-702-3560

Anthem Blue Cross and Blue Shield

www.anthem.com/statect
Enhanced Dedicated Member Services: 1-800-922-2232

Caremark (Prescription drug benefits)

www.caremark.com 1-800-318-2572

CIGNA (Dental and Vision Rider benefits)

www.cigna.com/stateofct 1-800-244-6224

Health Enhancement Program (HEP) Care Management Solutions (an affiliate of ConnectiCare)

www.cthep.com 1-877-687-1448

For details about specific plan benefits and network providers, contact the insurance carrier. If you have questions about eligibility, enrolling in the plans or payroll deductions, contact your Payroll/Human Resources office.